The Medical Care Programs of the Farm Security Administration, 1932 through 1947: A Rehearsal for National Health Insurance?

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ABSTRACT

At a time of renewed interest in universal health insurance, an examination of earlier periods when society grappled with the link between socioeconomic status and health is fruitful. Between 1935 and 1947, the federal government sponsored a comprehensive medical care program for low-income farmers, sharecroppers, and migrant workers under the auspices of the Farm Security Administration (FSA). Despite the strong opposition of the American Medical Association, humanitarian and economic concerns at the local level often promoted physicians' participation in the program's group prepayment plans. Many FSA leaders clearly saw the program as a model upon which national health insurance might advance. However, in the wake of World War II, the FSA program declined as physicians' income improved, the rural population declined, and traditional ideological objections to federal intervention in medical care resurfaced. The FSA experience illuminates the complex ideological, economic, and humanitarian motivations of American physicians in the face of health care reform. (*Am J Public Health.* 1994;84: 1678–1687)

Introduction

From 1935 to 1947, the federal government sponsored an extensive civilian medical care program under the aegis of the US Department of Agriculture's Farm Security Administration (FSA). The FSA's mission—to rehabilitate low-income farmers, sharecroppers, and migrant workers—led it to develop a comprehensive medical care program described by the *Saturday Evening Post* as a "gigantic rehearsal for health insurance."[1] At the program's peak, more than 650 000 poor farmers and a million migrants were enrolled in medical care cooperatives or farm labor clinics in a third of all rural counties (Figure 1). Although the New Deal has been richly mined by historians, remarkably little has been written about this "gigantic rehearsal" in the nearly half-century since it ended.[2–4]

Until the passage of Medicare and Medicaid, the FSA program was the largest government-sponsored program dedicated to providing medical care for a specified civilian group. The FSA's success owes much to strategies the agency adopted to promote its medical program among skeptical physicians. These strategies are relevant guidelines as our nation again confronts the issue of national health security. Eager to avoid confrontation with both local physicians and organized medicine, the FSA emphasized free choice of physician and voluntary participation. Its decentralized approach promoted local autonomy and gave physicians substantial but not absolute control over the operation of the medical care plans. Certainly, philanthropies, unions, physicians, and private industry sponsored various prepaid health care plans throughout this period and even earlier. However, the public/private character, extensive enrollment, comprehensive coverage provisions, and preventive orientation of the FSA program gives it a historical import that exceeds that of earlier or parallel health care delivery programs.

Throughout most of this period, the American Medical Association vehemently opposed federal involvement in medical care delivery. In spite of this opposition, physician support of the FSA plans at the grassroots level was substantial and was driven by humanitarian and economic concerns. While physicians saw the program as a temporary federal effort to provide medical care to an indigent group, the agency itself pursued a broader public health agenda. The FSA's extensive public and preventive health efforts and its systematic use of public health nurses, nutritionists, and US Public Health Service medical officers belie the public posture assumed by the agency. Over time, the FSA's multifaceted rural health programs and its eventual alliance with reformers favoring national health insurance made physicians increasingly uncomfortable. This discomfort coincided with physicians' improving incomes and the easing of the economic pressures on them in the years leading up to World War II. Growing congressional opposition to New Deal social legislation, the divisive debate over national health insurance, and concerted opposition to the FSA by conservative farm groups only added to the agency's woes. In sharp contrast, other

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privately funded voluntary group prepayment plans (e.g., Kaiser Permanente, Blue Cross, and physician service bureaus) were less vulnerable to attack and made steady gains in the postwar era.[5] In retrospect, however, the root cause of the FSA plans' eventual demise was an ideological conflict between the government and the medical profession.[6,7] For this reason, the history of the FSA medical care program illuminates the ideological, economic, and humanitarian motivations of American physicians in the face of health care reform.

Medicine and Health in the 1930s

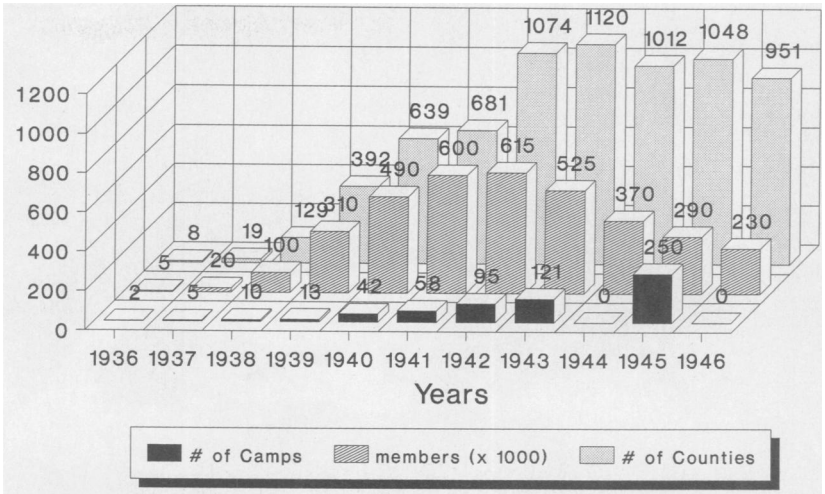
American medicine, like much of society in the 1930s, was in transition. Solo practice and fee-for-service still dominated medical practice, and rural hospitals were few and often proprietary. However, the waning influence of general practitioners, the rising dominance of specialists, and centralization of care in hospitals were well under way by that time.[8] In 1932, the Committee on the Costs of Medical Care published its landmark report *Medical Care for the American People,* the most exhaustive and influential study of the state of American health and medicine that had ever been published. The committee found that poor communities experienced more sickness and received less care than more affluent communities. Medical resources, while plentiful, were not "distributed according to needs, but rather according to the real or supposed ability of patients to pay for services."[9] The numerical, income, and geographical imbalance between general practitioners and specialists led the committee to conclude that the nation needed far fewer specialists and far more general practitioners. Finally, the committee linked access and cost barriers as critical issues for underserved populations, setting the tone for virtually all health care reforms to the present day.[10] An obvious but often neglected fact is that the most nettlesome problems in our health care system antedated changes such as the explosion of medical technology, the acceleration of medical specialization, and the dominance of hospital-based care in the wake of World War II. The committee's 1932 report calling for an integrated system in which generalists provide the majority of acute and preventive services was prescient.

The Great Depression greatly exacerbated but did not create the problems highlighted by the Committee on the Costs of Medical Care. Unemployment soared to an unprecedented 25%, overwhelming private and local relief agencies. Lack of money forced many people to go without medical services, and a single serious illness was enough to plunge a large and steadily increasing percentage of American families into prolonged debt. "I have to treat many families," lamented one physician, "shutting my eyes to the fact that not one of my instructions can be carried out."[11] Physicians' net income plunged by 17%, and many rural physicians' incomes dropped below 50% of billings.[12] Other health care professionals were similarly affected.

The Great Depression devastated rural America. Mechanization and land consolidation, the nation's worst-ever drought, and blunt legislative efforts such as the Agricultural Adjustment Act conspired to create the largest internal migration in our history. Vast numbers of families left their farms buried in dust, loaded up their jalopies, and headed west (see photo on next page). The Department of Agriculture estimated that between 1 and 2 million of the estimated 10.5 million people employed in agriculture were migrants.[13]

The health conditions of rural citizens, which had been declining relative to those of urban Americans since the turn of the century, were also adversely affected. Rural areas had 80 physicians per 100 000 population, vs 171 per 100 000 in urban areas. In 1900, nearly 50% of medical school graduates practiced in rural areas; by 1931, fewer than 21% did so.[14] In metropolitan areas, 72% of births occurred in hospitals, infant mortality was 34.2 per 1000 live births, and immunizations averaged 89%. In contrast, only 14% of rural babies were born in hospitals, rural infant mortality was 43.3 per 1000 live births, and only 37% of rural children were immunized.[15] In New England there were 81 hospital beds per 100 000 population, while in the more rural South there were only 30 beds per 100 000. Ninety-four percent of all water supplies in the South, according to the 1940 census, were open; 66% of Southerners still used privies, and fewer than 12% had potable water within 50 feet. A third of the nation's 3070 counties had no public health unit; virtually all were rural.[16]

Health conditions among migrants were particularly abysmal. Outbreaks of infectious diseases such as typhoid, dysentery, and tuberculosis created vigilante movements that were sometimes led by local health departments. Wrote one county health officer, "One has to deal with a people whose cultural and environmental background is so bad that for a period of more than 300 years no advances have been made in living conditions among them."[17] Racism, xenophobia, and fear of contagion—powerful historical themes in society's response to



Source. Based on data from the BAE report[31(p14)] and Mott and Roemer, *Rural Health and Medical Care.*[2(p407)]

FIGURE 1—Evolution of Farm Security Administration health programs, 1936 through 1946.

"Mother and Daughter Living on the Side of the Road," Nipoma, Calif, 1936. Photograph by Dorothea Lange, from the Library of Congress, Prints and Photographs Division, FSA Historical Division (LC-USF34-33601 17521).

disease epidemics—led to the violent and systematic destruction of squatter camps or "Hoovervilles." To many people, disease and degraded mortality seemed equally contagious.[18]

Roosevelt quickly moved to promote massive federal intervention during the famous "100 days" of his presidency. Congress passed an omnibus relief measure creating the Federal Emergency Relief Administration (FERA) in March 1933. The FERA channeled direct federal relief through state emergency relief administrations and created a division devoted solely to rural relief and rehabilitation. The hallmarks of the FERA rural rehabilitation program—friendly supervision and easy credit—remained at the core of all subsequent efforts. The creation of the Works Progress Administration (WPA) and the Resettlement Administration in 1935 signaled a shift in federal policy away from direct monetary relief. The more well-known WPA concentrated on massive infrastructure projects and urban work relief. The Resettlement Administration assumed the rural rehabilitation prerogatives of the FERA and operated for 2 years as an independent cabinet-level agency under brain truster and political lightning rod Rexford Tugwell. In 1937, the president renamed the Resettlement Administration the Farm Security Administration and placed it in the more conservative Department of Agriculture. In 1943, as part of wartime restructuring, the War Food Administration assumed responsibility for the FSA migrant programs.[19] (For clarity, the acronym FSA is used throughout this essay.)

The FSA promoted marketing, farming, and equipment-buying farm cooperatives to help smaller and poorer producers compete in the agricultural marketplace. The agency also believed that these cooperatives would promote economic stability, enhance self-reliance, and foster local leadership. Pressure on the agency to maintain good loan repayment among its rehabilitation clients soon conflicted with the FSA's humanitarian thrust, and when it became clear that ill health was responsible for 50% of all loan defaults, the FSA moved into the field of health care delivery. As US Public Health Service senior surgeon and FSA chief medical officer Ralph C. Williams stated, "a family in good health was a better credit risk than a family in bad health."[20]

Medical Care Cooperatives

Williams told those attending the 1939 American Public Health Association convention that the FSA medical program was an "incidental by-product of a depression-born loan program for farm families unable to obtain credit elsewhere, and designed to accommodate a special economic group only."[21] This economic justification pacified vocal groups unsympathetic to the agency's social agenda, such as organized medicine, conservative politicians, and organized farm groups. However, Williams' public posture understated the powerful ideological commitment of the agency's medical hierarchy to make more public the practice of medicine. In line with the agency's cooperative philosophy, local FSA supervisors encouraged farmers to establish medical cooperatives. These supervisors asked local physicians to provide care to FSA clients in a group prepayment scheme to lower cost barriers and ensure access to needed medical care. Bundled into their annual loans, rehabilitation clients (also called borrowers) received a federal subsidy (typically around $35), which they then paid into a trustee-supervised fund. Participating physicians billed this fund, and if billings exceeded the amount set aside that month, doctors received prorated reimbursement. Flexibility at the local level was critical to the program's success with farmers and physicians alike. The policy of promoting cooperatives and local determination of local needs also fit into the FSA's commitment to participatory democracy. "Any plan in which the families unite to help themselves should reduce the cost of medical aid and thereby make more effective the funds thus expended [so that] a worthwhile beginning can be made by the families themselves toward better health."[22] Healthier clients made the task of supervision easier, and credit risks diminished as clients' health improved. This fact not only was a source of pride for the agency but was also critical to continued congressional support. Nearly 90% of all loans were eventually repaid in full. The FSA plans were also a new source of income for hard-pressed rural doctors. Participating doctors collected 65% of their fees from a group that had previously been able to pay little, if anything, for medical care.[23]

It was not the intent of the FSA in the medical cooperative program to fundamentally restructure the delivery of rural health services. Group prepayment was grafted onto traditional fee-for-service practice. Concessions of this sort, along with the fact that physicians' participation was voluntary and the extension of care was limited to a specified low-income group, made the FSA programs palatable to financially strapped rural practitioners. Still, the agency's promotion of consumer

participation on the cooperatives' governing boards, the key fiscal and administrative role played by the FSA, and the lowering of cost and access barriers for low-income farmers represent genuine reforms for the era. Of equal importance, the medical care cooperative program gave the FSA experience it put to good use as it extended its health programs to migrant workers and experimented with more radical proposals.

Migrant Health Programs

The New Deal confronted the problem of migrant labor in the United States in early 1935 when the California state emergency relief administration built two farm labor camps, using federal and state rural rehabilitation funds. The mobility of the migrants made direct payments for medical care administratively cumbersome. Consequently, in 1937 the FSA devised a bold alternative means of providing medical services: Agricultural Workers Health Associations (AWHAs). By 1946, seven regional AWHAs were providing medical services in 250 federal migrant camps nationwide.

The FSA developed its first AWHA in California and Arizona following a tour of the region by Dr Ralph C. Williams. Shocked at the appalling health conditions of migrant families, Williams called for the creation of a "state-wide incorporated health association . . . to make direct payments to doctors and hospitals for medical and hospital treatment."[24] Williams wisely enlisted the support of leaders in the California Medical Association. In 1937, the FSA gave $1 million to the newly incorporated Agricultural Workers Health and Medical Association. California and Arizona physicians made their uneasy alliance with the government, mindful of the swelling tide of social and political support for medical care reform:

> There have been theoretical objections and charges that such plans are a step toward "State Medicine," "compulsory sickness insurance" or "socialized medicine." In evaluating such objections, it may be well to consider alternatives. News . . . reveals almost parallel movements . . . in the direction of greater intervention of government in medical care. [S]tatements of President Roosevelt and the Social Security Board officials [and] the effort of some hospital insurance plans to invade the field of medical practice . . . are portents of a trend in the United States. It is doubtful if head on opposition can greatly affect this trend.[25]

As was true with the medical care cooperatives, local FSA representatives, typically camp managers, recruited physicians into the AWHAs. AWHA doctors rendered services at agreed-upon fees and the AWHA paid them directly. Physicians' participation was voluntary, and the physicians insisted that the migrants have free choice in selecting their physicians. Full-time public health nurses staffed the camp clinics and referred patients to participating physicians' offices when necessary. Physicians also held clinic hours at specified times of the week and received payment on a per diem, hourly, or—occasionally—salaried basis. Whenever possible, the AWHAs used existing community hospitals as referral centers for their sickest migrants. At Eleven Mile Corner, Ariz, and Belle Glade, Fla, the FSA took the extraordinary step of owning and operating hospitals for its migrant clients.[26]

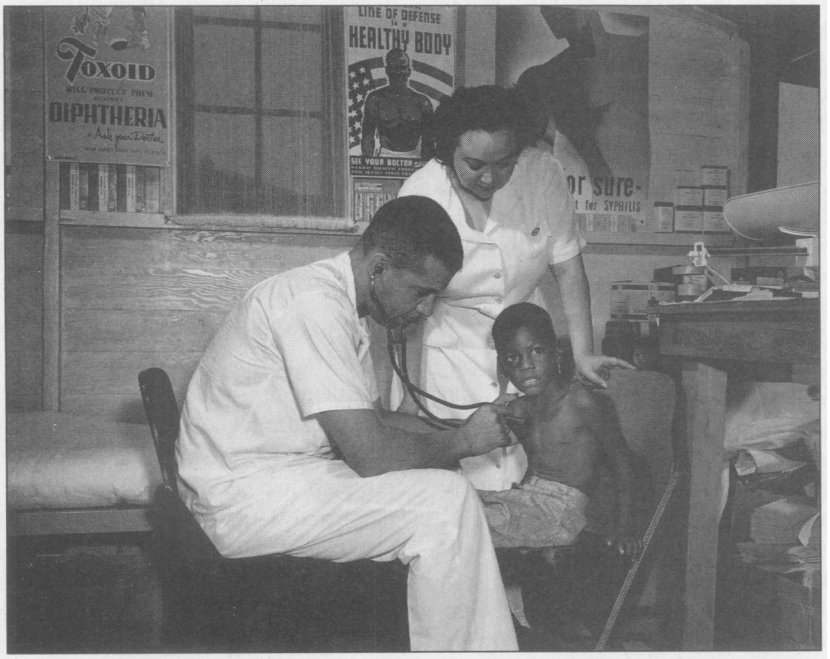
FSA district and regional medical officers showed pragmatism and flexibility in adapting the AWHAs to local needs and exigencies. Medical societies influenced but did not dictate the setting of fee schedules and limits of coverage, and they could even express grievances on staffing matters to FSA medical officers. For their part, FSA district and regional medical officers maintained liaisons with county and state medical societies, supervised the field medical and nursing personnel, and implemented public health policies whose influence often extended beyond the camps' perimeters. Considerable local autonomy resulted in substantial variations in the organization and character of the migrant health programs. In California, migrants were mainstreamed into local physicians' offices, while elsewhere camp medical clinics were the preferred sites for medical care. FSA programs occasionally became sources of care for nonmigrant FSA rehabilitation clients. Despite local variations, the structure and philosophy of the AWHAs were consistent from region to region: available and adequate medical services, government subsidization of costs, and a focus on preventive services, particularly for pregnant women and children.

By negotiating fee schedules, granting physicians substantial freedom in medical decision making, and making the programs voluntary, the FSA successfully used a strategy that was repeated in many subsequent battles over health care reform. Even more than its medical care cooperative program, the FSA's promotion of an organizational and fiscal entity such as the AWHA to provide access to health care signified a major shift in federal health policy. Using the AWHA as a surrogate payer preserved the appearance of independence upon which doctors insisted while effectively undermining physicians' opposition to more overt government involvement in medical care financing or delivery.

Resettlement Projects

One of the FSA's more controversial efforts was the creation of a series of resettlement projects and greenbelt communities throughout the country (e.g., Greenbelt, Md). Under the resettlement program, low-income farmers, sharecroppers, and farm laborers living in the resettlement "homesteads" were given housing, a small plot of land for personal use, and technical advice on cooperative farming and marketing. The federal government's promotion of the resettlement projects embroiled the FSA in a political maelstrom from which it never fully extricated itself. Critics charged that land redistribution and agricultural cooperative programs were proof that the FSA had been "vaccinated by the Tugwellian virus [and] placed into the hands and under the blight of social gainers, do-gooders, bleeding hearts, and long-hairs who make a career of helping others for a price and according to their own particular, screwball ideas."[27]

Resettlement projects provided on-site care by general practitioners, although there was a wide mix of hospital, dental, and specialist care. The FSA established health clinics staffed by full-time salaried nurses and either full-time or part-time salaried physicians in at least 40 resettlement projects. Often, resettlement communities formed incorporated health associations similar to the AWHAs and contracted with local physicians, hospitals, and dentists for discounted services. Archival evidence, although anecdotal, provides support for the benefits of the program. In 1939, the FSA's chief medical officer found that "the families require less care now than they did 2 years ago, that they abuse their privileges very little, that they call him early in illness, that he enjoys making repeat calls without feeling it a burden on the families, and that the general Farm Security Administration program has already shown results in healthier families, particularly the children."[28]



Agricultural Workers Health Association clinic, Bridgeton, NJ, 1942. Photograph by John Collier, from the Library of Congress, Prints and Photographs Division, FSA Historical Division (LC-USF 34-83435 17521).

Statewide Prepaid Plans

Perhaps no other region suffered the effects of the devastating drought of the 1930s more than North Dakota and South Dakota, two states where virtually everyone qualified for relief. In August 1936, alarm over rapidly deteriorating health conditions in the region prompted a meeting of local, state, and federal officials, including Surgeon General Thomas Parran, the WPA, the US Children's Bureau, the FSA, and organized medical groups of both states. Within a year, the FSA established two statewide capitated medical care plans in the drought-stricken Dakotas. The North Dakota and South Dakota Mutual Aid Corporations provided home and office medical care, hospitalization, major surgery, emergency dental care, nursing care, and drugs. The fee schedule was nearly 30% less than the prevailing minimums. Prevention and maternal and child services were integral components of these statewide programs, and the Mutual Aid Corporations even promoted clinical practice guidelines such as "an agreed minimum number of prenatal visits, delivery in the home or hospital, and necessary post-natal care."[29] Despite the fact that they received 60% of their billings, physicians opposed the prorating of bills so vigorously that the two statewide medical care experiments ended after 2 years of stormy operation.[30]

Experimental Rural Health Programs

Although the medical care programs and the AWHAs represented the most extensive and successful of all FSA medical care efforts, the agency undertook demonstration projects that were far more controversial. These experimental health programs went significantly beyond what agency leaders considered to be limitations of the earlier and more established programs for rehabilitation borrowers and migrant workers. In these earlier efforts, voluntary enrollment—insisted upon by physicians—led to an adverse selection effect. Families most likely to use services enrolled in the group payment programs while healthier families preferentially opted out of the group payment plans in favor of traditional fee-for-service arrangements. Certainly, pressure from local physicians strongly influenced this trend. Yet despite strenuous educational efforts by the FSA, the economic advantage of paying in advance for medical care, regardless of anticipated need, remained a difficult concept for many farmers. In response to this trend, the FSA considered alternative ways of improving the actuarial soundness of group medical care plans. The FSA developed experimental rural health programs to resolve this dilemma. Fiscal stability was achievable, the agency argued, by distributing the costs of illness over a broader patient base through countywide medical care plans with no income restrictions. Agency leaders also believed this strategy could promote higher reimbursements for physicians while allowing yearly membership fees to be income-adjusted and moderate, thereby generating broader community support.

Beginning in 1942, the FSA selected seven rural counties with an interest in medical care, reasonably stable income, sufficient medical and hospital facilities, and receptive local physicians. Of cardinal importance was the FSA's preference for counties with full-time public health units. This criterion was a reflection of the long-standing relationship between the FSA and the Public Health Service. Indeed, many of the leading figures in the medical care experiments of the FSA were Public Health Service officers who shared that agency's commitment to bringing public health back into the heart of medical care delivery. The experimental health programs adopted a sliding-scale membership fee, and the government subsidized the remaining costs. This federal support was necessary to enable lower-income families to participate and to allow the programs to include preventive services, hospitalization, drug costs, and dental work. The FSA created six rural health services (as they were generally called) in Texas (Wheeler and Cass counties), Mississippi (Newton County), Nebraska (Hamilton County), Arkansas (Nevada County), Georgia (Walton County), and New Mexico (Taos County). An even more ambitious six-county experimental health program was begun in southeastern Missouri.

The services provided by the experimental health programs reflected the FSA's consistent public health and primary care orientation. General practitioner services included office, home, and hospital visits. Surgical or subspecialty consultation was available with a referral by the general practitioner. Dental services covered not only emergency care but also routine and prophylactic treatment. All seven programs initially covered drug expenses. The experimental health programs maintained the characteristic flex-

ibility of the FSA medical care programs. Membership fees based on ability to pay, voluntary choice of available physicians, broad scope of services, voluntary participation by physicians and farmers alike, and local administration were constants. However, financing mechanisms varied and included modified fee-for-service plans, capitation, and full- or part-time salaried medical staff.[31]

Acceptance of these experimental programs was generally high among rural families eligible for participation, and membership as a percentage of population in the first year of operation ranged from 32% to 74%. Turnover remained a serious problem, however, sometimes reaching 50% per year.[32] When queried about their lack of ongoing interest, farmers usually cited the high membership costs of the program and their feeling that they were not receiving the services for which they had paid. Members were often unaware that the federal government subsidized most of the programs' costs, and the FSA found that out-of-pocket payments for medical care, alternative healers, and drugs were common. Although the experimental health programs were explicitly designed for a broad cross-section of the community, the public's perception that they were for disadvantaged farmers was hard to eradicate. Doctors reinforced this perception and discouraged middle-income families from joining.[33]

Few credible data on whether the experimental health programs had a beneficial effect on members' health exist. Basic vital statistics at that time were notoriously inaccurate, particularly in rural areas. It was also an era when few questioned the assumption that more medical care resulted in improved health:

> More mothers are now receiving prenatal and postnatal care, and better medical care and more hospitalization at childbirth. Patients are going to a doctor oftener and earlier, and are making more use of hospitalization facilities. Many families reported an increased feeling of security.[34]

Viewed in this light, the experimental health programs and the FSA program in toto were successful by commonly accepted measures, such as number of physician visits, hospitalization rates, number of prenatal visits, number of physician-attended or hospital births, and immunization rates. Experimental health program members received, on average, 2.6 physician visits per year, double the number cited by the Committee on the Costs of Medical Care for rural citizens. Prior to the establishment of the Nevada County program, only 10% of White women in the county delivered in hospitals, although nearly 90% were attended by a physician. In sharp contrast, Blacks delivered at home 99% of the time, nearly all attended by midwives or experienced neighbors. After the experimental program began, 50% of White babies and more than 25% of Black babies were born in the local hospital, while the percentage of physician-attended births for Blacks climbed to 75%.[35] Similar dramatic changes in obstetrical practice occurred in Taos County, which had a predominantly Spanish-speaking population. The annual number of hospitalizations for delivery in the fledgling Blue Cross plans was 107 per 1000 members, compared with 155 per 1000 in the experimental health programs.[36]

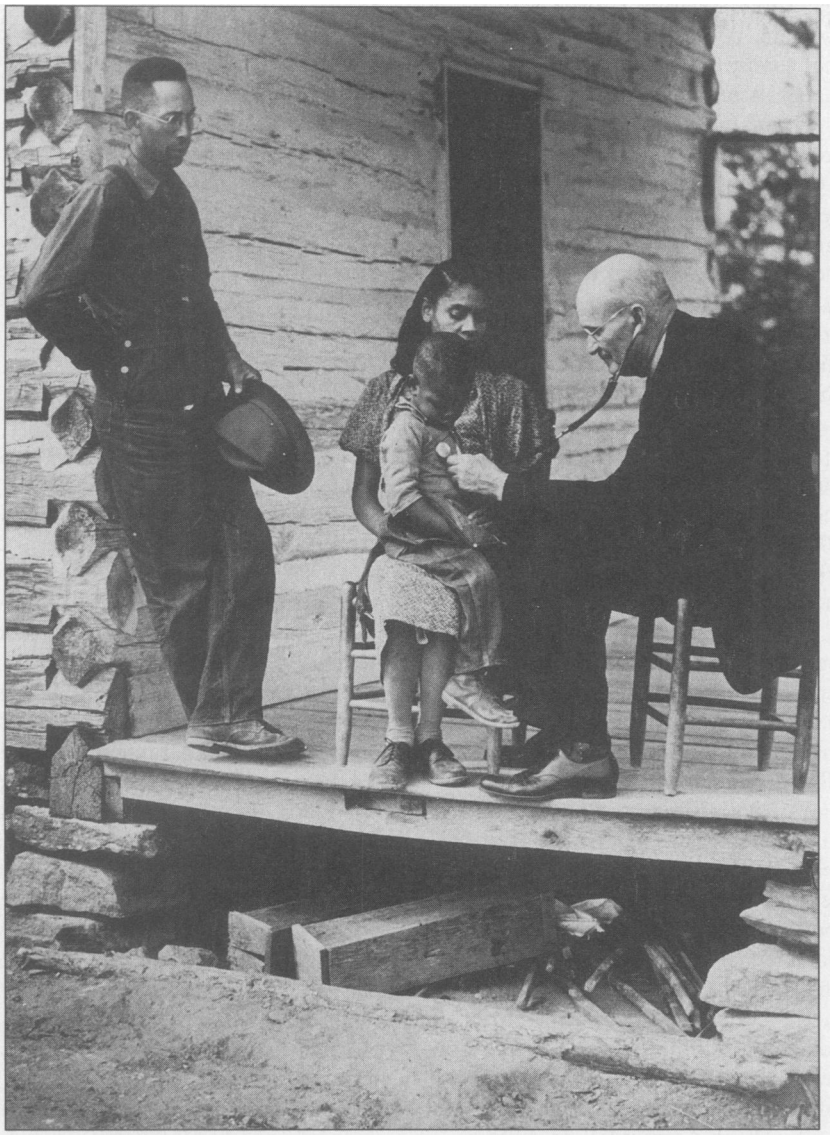
The experimental health programs were born of the conviction of FSA leaders that major structural and financial changes in America's health care system were imminent. A 1944 poll found that 68% of Americans supported an extension of Social Security to cover medical care and hospitalization; 89% felt that some people did not get medical care because of cost barriers; and 33% had themselves deferred treatment for financial reasons.[37] Many ranking FSA medical officers firmly believed that the nation would eventually adopt some form of national health insurance. These leaders believed that the experimental health programs afforded an unparalleled opportunity to gain practical experience in operating what might become a model for a future national system of medical care delivery. Former FSA chief medical officer Frederick D. Mott and his former assistant Milton I. Roemer wrote in 1948 that the experimental program had "given us what is probably an unmatched body of experience in the possible achievements and deficiencies of the tax-assisted and voluntary health insurance plans in rural areas."[38]

The experimental health programs experienced many of the same problems that beset earlier FSA health care delivery programs. The perception that the programs were for the indigent, reinforced by physicians who discouraged higher-income families from signing up, and the high turnover rate among families who used fewer services adversely affected the programs' actuarial soundness. The drain of younger, more able-bodied rural citizens to the armed services and urban-based defense industries left behind groups—women, children, and the elderly—with higher than average health care utilization, further exacerbating the adverse selection effect. Although professional misgivings were evident early on, many physicians supported the plans with the understanding that "the proposed association would in no way interfere with physicians in the practice of medicine and that patients would have free choice of physicians."[39]

The Medical Profession's Response

The reasons behind the FSA's initial success in recruiting rural practitioners are worth examining. First, the FSA's explicit goal was to provide medical care for a low-income population that was severely straining local medical resources. While doctors worried about the potential of the FSA programs in terms of a broader federal health agenda, the plans provided timely financial relief to hard-pressed rural general practitioners, driving them into a temporary alliance despite opposition by the American Medical Association. Free choice of physician, voluntary participation by client and practitioner alike, and control over matters of medical practice were core elements in the FSA health program. The FSA dealt only with medical doctors or their representatives, excluding osteopaths, chiropractors, midwives, and other folk practitioners. This policy strengthened the government's hand with the highly vocal and well-organized medical profession, the group whose authority over the practice of medicine was approved of by a public increasingly convinced of the benefits of scientific medicine.

At the center of the FSA plans were primary care practitioners, both physicians and nurses. This emphasis was crucial to the programs' successes for more than a decade. While not without its pragmatic side (after all, the majority of physicians available to the agency in rural areas were general practitioners), this strategy mirrored the convictions of the FSA medical leadership and harkened back to the recommendations of the Committee on the Costs of Medical Care. Well before World War II, the complementary forces of specialization and centralization were undercutting the central presence of the general practitioner in American medicine. Thus, the FSA programs bolstered the flagging financial and professional fortunes of the rural general-



Caswell County, North Carolina, 1940. Photograph by Marion Post Wolcott, from the Library of Congress, Prints and Photographs Division, FSA Historical Division (LC-USF 34-56376-D).

ist and provided doctors with a powerful, if potentially worrisome, ally in the profession's emerging sovereignty over medical practice.

Local, regional, and national politics influenced physicians' receptivity to the FSA plans. Statements that the plans violated medical ethics and the sanctity of the physician–patient relationship were commonplace. Many county and state medical societies, and invariably the American Medical Association, preferred the status quo to any government-sponsored health insurance program. As late as 1938, editors of many state medical journals mouthed official American Medical Association policy: "These are problems for local and state consideration . . . rather than problems of federal responsibility."[40] While physicians who supported the plans defended their position in the *Journal of the American Medical Association* and state medical journals, many doctors vociferously contended that the plans provided inferior care and that "medical services did not lend [themselves] to cooperative handling."[41] Clearly, medical care plans based on anything but the traditional fee-for-service engendered significant distrust among physicians. Even at the county level, where support for the FSA programs was most deep rooted, conflicts invariably emerged. Physicians charged above the established fee schedule, collected fees on the side, and double billed—all in violation of their agreements with the FSA. Physicians pressured rehabilitated families to cancel their membership, since a family that had paid off its debt was "no longer in need and [could] afford to purchase medical services privately."[42] Finally, many physicians responded to the prorating of bills by limiting service rather than increasing their attention to prevention, as the agency had naively expected. Doctors preferred strict definitions of medical eligibility, while the FSA's eligibility criteria and definitions of medical need were generous. For physicians, the laxity of the FSA's eligibility criteria, exemplified by the use of the AWHA camp medical clinics by nonindigent local residents, was an omen of a more threatening, unstated federal agenda.

Tension between the government's advocacy on behalf of low-income rural Americans and the medical profession's desire to control the practice of medicine eventually threatened the uneasy alliance that promoted the federal programs. Conflicts over the composition of supervisory boards, eligibility criteria, and, of course, payment were continuous. World War II's effect on already scarce rural medical manpower, the shifting funding priorities of Congress, and a growing political backlash against the social agenda of the New Deal exacerbated many of these conflicts. The impressive growth of the FSA health program notwithstanding, difficulties were evident even in the earliest stages of the FSA's involvement in health care. From 1938 on, termination of medical cooperatives accelerated, although the program peaked in terms of membership in 1942.[43] Powerful and deeply felt ideological positions within the medical profession had as much to do with the eventual dismantling of the medical care programs as the disruption caused by the war.[44]

The Great Depression marked a significant shift in the locus of charity and public welfare programs from philanthropists and local government to the federal government. The 1935 Social Security Act and other New Deal social legislation irreversibly broadened the federal government's responsibility for social welfare in America. While the American Medical Association stressed throughout the Depression that the care of indigents was a local concern, powerful financial and humanitarian concerns temporarily over-

rode physicians' traditional ideological opposition. Many local physicians and state medical societies accepted the FSA's role as a fiscal, organizational, and administrative intermediary. This schism certainly promoted the remarkable growth and development of the FSA's health programs. The threat of national health insurance drove constituent medical societies and individual practitioners to consider alternative methods of financing and delivering medical care.

The suspicions voiced by physicians that the FSA programs were a harbinger of a federalized health care system were not mere professional paranoia, nor were they inconsistent with many readily apparent facts. FSA leaders anticipated fundamental changes in the nation's health care system, and many in Washington expected the vast experience gained in the FSA plans to shape these reforms. FSA leaders actively participated in the deliberations of the Interdepartmental Committee for Health and Welfare Activities that supported the expansion of public health services and grants-in-aid to states for hospital construction, programs for the medically needy, and state-based general medical care programs. The committee's recommendations led directly to the 1938 National Health Conference. Soon after this conference, the American Medical Association reversed its long-standing opposition to voluntary health insurance in an extraordinary emergency meeting of its house of delegates.[45] In 1942 the FSA took a leading role in the Interbureau Committee for Post-War Programs in Agriculture, charged by the president to develop "all possible phases of a health program for the entire farm population now."[46] The FSA's ownership of two hospitals, its promotion of salaried and clinic-based practices, and its experimental health programs testify to agency leaders' interest in pushing the boundaries of federal involvement in health care delivery. The frequent use of Public Health Service officers to provide, administer, and organize rural medical services—an early harbinger of the National Health Service Corps—is further evidence of this agenda. In 1946 a youthful New Deal senator from Florida, Claude Pepper, noted in particular that the experimental health plans, "based on the tax-assisted voluntary health association principle, constitute a series of experiments of interest to the whole Nation. They are particularly important at this time, when our whole future national health policy is being decided."[47] Dr Mott confirmed Senator Pepper's views, saying that the experimental health plans "hold lessons for every rural community and for urban as well as rural Americans . . . [a]t a time when the nation is facing its health problems, weighing possible solutions, and rapidly approaching the stage of long-needed action."[48] It was with conscious deliberation that the agency downplayed this more progressive agenda during the evolutionary phase of the medical care plans.

Events in Europe and increasing fiscal and political conservatism in Congress profoundly altered the reform spirit characteristic of the early Roosevelt presidency. Between 1942 and 1946, the FSA embarked on a number of creative efforts to stave off criticism, such as having its nurses conduct Red Cross first aid programs. These efforts ultimately proved unsuccessful. The FSA was unable to withstand the attacks of conservative farm organizations and congressional opponents who had long waited to eviscerate the agency. In 1947, the FSA was transmutated into the far meeker Farmers Home Administration. Simultaneous with these developments, the allegiance of physicians shifted to groups antagonistic to the FSA's reform agenda. Dr Mott's warning in a confidential memorandum to his staff that an "unholy alliance" between the American Medical Association and the Farm Bureau could undermine the FSA health programs proved valid.[49] For example, in 1946 the California Medical Association abrogated its agreement with the FSA in favor of a group insurance program sponsored by the Farm Bureau and the Grange, two groups whose antipathy to the FSA was well known.[50]

Factors operating on a national scale were catalysts in the decline of the FSA's political fortunes. The war economy's beneficial impact on physicians' income and the scarcity of medical personnel resulting from the draft lessened the economic incentives that had previously generated flexibility on the part of doctors.[51] Stiffening resistance to further federal encroachment into medical care delivery was evident in physicians' initial opposition to the Emergency Maternal, Infant and Child Act.[52] The stumbling momentum toward national health insurance further crippled the agency, whose medical leaders were by then openly in support of a comprehensive national health program. The difficulties faced by the FSA medical leadership since the program's inception were evident in Dr Mott's response to a request to present his agency's position on the 1943 Wagner-Murray-Dingell national health insurance bill. The request, wrote Dr Mott confidentially to his colleagues, "raises an important question about the dilemma—which is not new to any of us—that of working for certain goals privately and yet having to take carefully considered stands publicly."[53] Indeed, as a matter of political and pragmatic expediency, FSA medical leaders downplayed their support of national health insurance. Privately, they remained optimistic that the FSA experience would move a national health program forward, although their optimism went unrewarded.[54]

Conclusion

The experience of the FSA health program yields insights into the often uncomfortable relationship between medicine and the federal government during periods of health care debate. Historically, the medical profession has been loath to place itself at the forefront of health care reforms. However, under financial duress, carried in the wake of a nationwide spirit of social reform, and undoubtedly faced with interventions that appeared inevitable, physicians played a vital role in the FSA health care program. Left to their own impulses and freed from the coercive effect of economic distress, they renewed their traditional opposition to federal involvement in health care. Although the FSA program expanded until World War II, physicians' dissatisfaction with and nonrenewal or outright abrogation of agreements accelerated from 1938 forward. Ultimately, physicians remained wary of third-party intermediaries and willingly allied themselves with the organized farm groups who were the architects of the FSA's demise.

The federal government's foray into health care delivery was not a wasted effort. By intervening directly in the provision of medical care services for underserved civilian populations, the government established a broad precedent. Not until the passage of Medicare and Medicaid, the creation of the Office of Economic Opportunity, and the neighborhood health center movement during the Kennedy-Johnson era would such a vast number of poor Americans gain access to medical care through lowered cost barriers. The economic and humanitarian factors that promoted the FSA's program are of central importance. Certainly, hundreds of thousands of rural Americans experienced their first regular source

of medical care and received immunizations, nutritional advice, and physical nurture within the friendly, if paternalistic, embrace of the federal government. By participating in FSA plans, physicians served both their financial and their more noble goals. Both physicians and clients experienced firsthand the role that fiscal and administrative intermediaries could play in the traditionally sacrosanct doctor–patient relationship. Postwar history shows that it was the private sector and not the federal government that benefited most from this initiation process.[55]

The agency's interdisciplinary approach to providing services demonstrates its public health and primary care orientation. The FSA's plans were centrally financed but organizationally decentralized. Since they revolved around the provision of care by generalists, they ran counter to the prevailing direction of American medicine. The plans reinforced the professional and economic security of rural general practitioners. The FSA's routine incorporation of such supposedly recent health care innovations as the primary care gatekeeper, the use of nurses as physician extenders, and preventive service was also a notable accomplishment and reflects an early federal experiment in managed care. Finally, many at the time believed that the FSA experience would shape a national health insurance plan that they believed was imminent. Congressional hearings on national health policy and the visible and active role given to the FSA medical hierarchy in postwar health care planning substantiate this view.

Although it was not the focus of this essay, the FSA's influence rippled well beyond the 12 years of the agency's existence. Many public health–oriented physicians who worked in the FSA program went on to shape future health care reforms, both in the United States and abroad. Dr Mott moved to Saskatchewan in 1945 and helped mold its provincial health care plan, which was the model for Canada's national health care system. The progressive movement in medicine and public health, programs such as the United Mine Workers Health and Welfare Fund, and the Office of Economic Opportunity owe a debt to such luminaries as Milton Roemer, Loren Kerr, George Silver, Sy Axelrod, Les Falk, Joseph Mountin, Martha May Eliot, Henry Makover, and many others with ties to the FSA.[56] As Dr Mott wrote to his dispirited colleagues from his vantage point in Canada, "We can have the satisfaction of spearheading a movement which will ultimately benefit every citizen. . . . [O]ur consolation can be that we played an historic role at a time when pioneering was urgently needed."[57]

The FSA medical care program remains one of the earliest, most extensive, and certainly most comprehensive federal efforts in health care delivery. It incorporated precepts usually considered more contemporary, such as consumer participation, decentralization of care, centralization of payment source, and an abiding focus on prevention and health education. Strategies that controlled costs, such as the use of nurse clinicians, salaried physicians, and administrative controls on referrals and hospitalization, all speak to the agency's prescient approach to health care delivery. Finally, the FSA provided hundreds of thousands of rural families with their first taste of insurance-based medical care. One participant believes that the FSA experience helped spur the dramatic postwar growth of the private health insurance industry in rural America.[58]

The FSA experience illuminates many characteristics of American medicine that are relevant to the current health care policy debate. Its historical importance as the most extensive New Deal foray into health care delivery notwithstanding, the experiment foreshadowed or directly influenced various health care delivery models in this country and abroad. Forces that contributed to the FSA's remarkable growth and eventual demise provide insight into the role of government and physicians in health care reform. Universal health insurance has resurfaced on our nation's political agenda. The FSA experience, seen as a dry run for a national health program, undermines the myth that government cannot play a creative, fiscally responsible, and professionally acceptable role in health care financing and delivery. □

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